DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES
PERSON-CENTERED PLANNING GUIDELINES

SUMMARY AND BACKGROUND

The State Plan: A Blueprint for Change establishes person-centered planning as fundamental to reform within the mental health/developmental disabilities/substance abuse service system. Person-centered planning is a process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to everyone supported and served in the system. Person-centered planning provides for the individual with the disability to assume an informed and in-command role for life planning, and treatment, service and support options. The individual with a disability and/or the legally responsible person[1] directs the process and shares authority and responsibility with system professionals about decisions made.

Person-centered, family-focused methods are used to identify life outcomes and determine strategies for achieving the outcomes. For all individuals receiving services, it is important to include people who are important in the person's life such as family, legal guardian, professionals, friends and others as identified by the individual (i.e. employers, teachers, faith leaders, etc.). These individuals can be essential to the planning process and help drive its success. The plan "is more likely to be strengths-based and recovery-oriented where planning is undertaken in true partnership with the individual and families and where agencies, policy makers and funders value and monitor outcomes such as individual and family satisfaction, community integration, needs met, quality of life and achievement of individualized goals."[2]

Person-centered planning uses a blend of paid and unpaid, natural and public specialty resources uniquely tailored to the individual/family needs and desires. Publicly funded specialty services are often critical for treatment and habilitation of individuals with disabilities, however, some needs can best be met by communities and naturally

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[1] *The emphasis in person-centered planning is on the individual identified to be served by the public system. Involvement of others in the process is affected by the legal status, age and treatment category of the individual.*

(1) *All adults are considered to be competent unless appointed a guardian by the court; the competent individual is responsible for directing the process with assistance of others who are chosen by the individual to assist.*

(2) *For adults who have personal, financial, general or limited guardians, or other legally identified relationships such as powers of attorney, representative payees, etc., the persons providing those legal functions are included in the planning process in regard to their legal responsibilities.*

(3) *Children's parents are presumed to be legally responsible unless that authority has been removed by the court. In the same way that parents help a child prepare for adulthood, as a child gets older, he or she is allowed to assume more of a role directing the plan. If legal authority has been given by the court to another person, that person makes all final decisions related to planning; however, the parents, other family members and caregivers are involved to the extent possible in the process. In this document, when referring to involvement of the individual/family, this legal framework is used. There is one exception: A minor may give consent to a physician for "medical health services for the prevention, diagnosis, and treatment of abuse of controlled substances or alcohol" per NC General Statute 90-21.5*

[2] Individualized Service/Support Planning, *Janet S. Walker, Ph.D. Research and Training Center on Family Support and Children's Mental Health.*

occurring supports. Therefore it is important for the person-centered planning process to explore and utilize both paid and unpaid sources of support.

Although the literature identifies specific methods for person-centered planning, these guidelines do not support one model over another. However, in the case of children and youth with mental health needs, the Division does recommend that the System of Care Child and Family Team process be used. There are also many tools that can assist in more effectively completing the process of person-centered planning. Different tools and emphases may be appropriate depending on disability category, age and circumstances. However, generally all of the approaches share common themes and elements, which are further defined in these guidelines.

VALUES AND PRINCIPLES UNDERLYING PERSON-CENTERED PLANNING

The key values and principles serving as the foundation of person-centered planning are as follows:

1. Person-centered planning builds on the individual's/family's strengths, gifts, skills, and contributions.
2. Person-centered planning supports consumer empowerment, and provides meaningful options for individuals/families to express preferences and make informed choices in order to identify and achieve their hopes, goals, and aspirations.
3. Person-centered planning is a framework for providing services, treatment and supports that meet the individual's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
4. Person-centered planning supports a fair and equitable distribution of system resources.
5. Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community, as they choose
6. Person-centered planning sees individuals in the context of their culture, ethnicity, religion and gender. All the elements that compose a person's individuality are acknowledged and valued in the planning process.
7. Person-centered planning supports mutually respectful and partnering relationships between providers/professionals and individuals/families, acknowledging the legitimate contributions of all parties.

ESSENTIAL ELEMENTS

Person-centered planning and plans shall adhere to the following essential elements:

A. The Person-Centered Plan as a Unified Life Plan

The Person-Centered Plan is the umbrella under which all planning for treatment, services and support occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance. It focuses on the identification

of the individual's/family's needs and desired life outcomes--not the request for a specific service. The plan captures all goals and objectives and delineates each team member's responsibilities within the plan.

Real life outcomes are described and related to life domains. Examples of life domains include housing, career and employment, education, finance (including entitlements and insurance), health, safety, clinical, social, intimate relationships, friendships, transportation, spiritual, legal, civic, communication, cultural, and emotional dimensions. Integrated strategies may cover more than a single life domain and different life domains may be covered at different times. Life outcomes to be pursued at any given time are directly related to priorities of the individual/family in relationship to life circumstances, situations and conditions as well as consideration of immediate needs and long term desires.

B. The Planning Team

Development of the planning team incorporates the following:

The individual to receive services is directly involved in the person-centered planning process to the extent possible. The individual and/or the legally responsible person(s), identifies who will participate in the planning process, how and to what extent. Those individuals identified to participate will comprise the planning team. The extent to which the planning team assists the individual with describing his/her goals, preferences and needs will vary with circumstances, based on such things as the individual's cognitive skills and understanding, status of illness, age, and physical limitations. In an emergent/crisis situation, the individual's ability to make choices may be limited; however, the values and principles of person-centered planning are the same. In these situations, it may be necessary for others in the person's life to take a more active role until the individual is more stable;

AND

The process includes participation by professionals and paraprofessionals that have been involved with the individual and diagnostic and assessment information gathered. For children this includes the Child and Family Team. Participation by these professionals/paraprofessionals can consist of attending meetings or sharing information outside of the meetings, both in formal and informal conversations, according to preference and negotiation with the individual/family regarding who should be involved in the process and how;

AND

The planning process honors the schedule and comfort of the individual/family and assists them in identifying resources to address transportation, childcare, and other needs for participation. Information discussed with the individual/family or collected from others must be communicated in a way that they understand. Gathering information from the individual, family members or others to include in the plan can occur in addition to the planning meetings.

C. Goals and Strategies to Meet Desired Life Outcomes

Meeting the treatment and primary service and support needs of the individual in order to insure health and safety is the primary focus of the planning process. These needs can be met in a variety of ways. Potential service, support and/or treatment options to meet the goals and needs of the individual/family are identified and discussed in collaboration with professionals in the public system of services. The individual/family/legally responsible person must be fully informed of the rationale, evidence and risks of specific service, support and treatment options in order to make responsible choices based on the options presented.

While purchased or funded treatment and supports may be necessary, they may not contribute to the individual's development and maintenance of relationships or to community integration. Therefore, care should be taken to assure that purchased or funded supports do not take the place of natural supports and community resources when they are available and appropriate to the need. In addition to purchased treatment and services, the following avenues should be explored for ways to contribute to the accomplishment of life goals.

- **Personal Resources**: The person's own resources should be examined and included in the plan. For example, the person may possess a special skill that can be useful or may have tangible resources that can be used.
- **Natural Supports**: Person-centered planning develops and enhances the use of natural supports such as family, neighbors, co-workers, and friends whenever possible. Existing supports in the individual's life must be recognized and documented, and unexplored natural and community supports must be explored.
- **Community Resources**: Opportunities to connect the individual/family to the community must be explored and offered, based on discussions with the individual/family as to the extent of community involvement desired. This includes efforts to access and secure community resources chosen by the individual/family as part of the strategies to support the individual's pursuit and achievement of plan-related life outcomes. Examples include involvement in church or faith-based organization, Boy's or Girl's Club, YM or YWCA, special interest or civic groups, sports or any other group available to other community members.

D. Addressing Health and Safety Needs

The health and safety needs of the individual are identified as part of the planning process in partnership with the individual/family, and must be addressed in the plan. Supports to maintain the individual's health and safety should be developed within the context of the individual's/family's preferred lifestyle, as much as possible.

If a situation is chosen that may be unhealthy or risky, the possible consequences of that choice should be discussed and the risks weighed against the preferred lifestyle and goals. The individual/family must be aware of the risks in order to make informed choices. If the individual/family comprehends the risks involved and is willing to take those risks, the individual/family should be supported in the lifestyle of choice. Plans should be made for supports to assist the individual/family in dealing with any consequences of choices. Documentation should be made of these discussions and choices made.

1. Preparations for Potential Crises

The planning process identifies early known warning signals and triggers of an impending crisis and the necessary interventions to ensure the health and safety of the individual and others. It provides proactive plans to prevent crises from occurring as well as reactive planning and crisis contingencies that are aimed at avoiding diminished quality of life when crises do occur. Careful crisis planning should prevent over-reliance on the crisis system; any use of the crisis system once the person-centered plan is developed should be carried out as planned.

As an example of a proactive plan, NC law provides for an *Advance Directive for Mental Health Treatment* (G.S. 122C-77). Completing this document provides individuals with the opportunity to plan in advance for a time in the future when they may need treatment but are not capable of communicating or making treatment choices. Other examples of advance planning for crises include relapse prevention for individuals with substance abuse issues, strategies for diversion from hospitals and from involvement in the justice system, wellness recovery action planning for individuals with mental illness, and addressing challenging behaviors for individuals with developmental disabilities and for children and adolescents.

Person-centered planning in an emergency situation first focuses on the individual's/family's immediate needs by providing services and/or supports aimed at stabilizing the crisis situation and ensuring health and safety. A crisis plan must also include what process or procedure will be followed when a crisis event or emergency situation occurs, such as who to call, what actions to take with the individual in crisis, what crisis services or hospitals should be used.

E. Individual/Family Disagreement with the Plan

A good person-centered planning process will usually result in a plan of consensus by all parties. However, there may be rare times when the professional cannot support the individual/family's choices for legal reasons or professional ethics. Another possibility is disagreement between the individual/family and professionals regarding the amount of service that is needed or that can be funded. The individual/family identify preferences and choices and, if not accepted and provided, they have access to a dispute process to address and resolve disagreements and to ensure fairness and equity.

F. Changing the Plan

The individual/family/legally responsible person is provided with opportunities to refine and change the continually evolving plan as new opportunities arise or when significant changes occur. There are ongoing opportunities to provide feedback about how they feel about the services, supports and/or treatment they are receiving and their progress toward achieving outcomes in specific life domains. The feedback is collected and used to make changes in individual plans as well as incorporated into the quality improvement processes of the agency. Plans must be reviewed at least annually or as required by funding sources.

G. Required Content for Documentation

Regardless of the person-centered planning model used, every plan must include the following elements:

1. Individual needs, preferences, and outcomes as identified and prioritized by the individual and/or family.
2. Information obtained in the assessment process, including diagnosis and functional status in life domains.
3. Potential issues of health and safety, and services and supports to address these issues.
4. A proactive as well as reactive crisis contingency plan.
5. Priority goals and measurable objectives expressed by the individual/family/legally responsible person.
6. Specific strategies, activities, supports, services, and/or treatment to achieve goals and objectives including frequency and duration. All resources, including natural and community, must be included within the plan. Because the person-centered plan is the umbrella under which all planning for support and treatment occurs, all facets of treatment and support provided must be documented within it. Separate plans should not be developed by other providers, or if they are, they should be referenced and incorporated into the person-centered plan. Potential resources must be addressed including:

   a. Individual resources.

   b. Family, friends, guardians, and others.

   c. Resources in the community.

   d. Publicly funded services/supports for all citizens.

   e. Publicly funded services/supports through the MH/DD/SAS Specialty system.

7. Individuals responsible for completing or following through with the activities, strategies, supports, services and/or treatment
8. Signature of:

   a. The competent adult individual or the legally responsible person of an adult deemed incompetent, OR

   b. The parent or legally responsible person for a child, OR

   c. A minor receiving substance abuse treatment.

   The signature acknowledges agreement with the documented elements of the plan. It is helpful although not required to get signatures of other parties to the agreement.

9. Documentation of individuals who participated as part of the planning team.
10. Documentation of any areas of disagreement and the steps to address the dispute process.
11. Evidence of ongoing review and updating to reflect changes in circumstances, supports or services, and progress toward meeting life goals.

Integration of goals, objectives, services and supports arising from other additional assessment or services that may be provided following the initial planning process. Documentation of significant level of service changes.

H. Indicators of Person-Centered Planning Implementation

Compliance with the requirements for person-centered planning can be shown by systemic[3] and individual[4] indicators that demonstrate that person-centered planning has occurred. Methods of gathering information or evidence regarding person-centered planning compliance may vary. They may include review of administrative documents, clinical policy and guidelines, case record review and interviews with individuals and families.

1. Individual Indicators

Individual indicators would include, but not be limited to:

1. Evidence that individual/family was provided with information of his/her right to person-centered planning.
2. Evidence that the individual/family had choice regarding topics discussed or not discussed in any meetings, and who would be present and/or involved during planning meetings. There should be further evidence that those individuals identified to be involved were included in the planning and implementation process.
3. Evidence that the individual/family had informed choice in the selection of providers including staff to assist in carrying out the activities of the plan.
4. Evidence that the individual's/family's preferences and choices were considered and implemented or changes cooperatively negotiated. If the individual/family disagreed with an outcome, there should be evidence that the dispute process was described and that the individual/family assisted in the process. There should also be documentation of the outcome of the dispute process.
5. Evidence that progress was made toward achieving the valued outcomes identified by the individual/family, and that they were reviewed and discussed so that strategies and techniques could be changed as needed to achieve these outcomes.

2. Systemic Indicators

Systemic indicators would include but not be limited to:

1. Evidence of a policy or practice guideline that delineates how person-centered planning will be implemented.
2. Evidence that all tools used at screening or assessment reflect person-centered philosophy, values and thinking.
3. Evidence that individual/families are informed of their right to person-centered planning and dispute process if they disagree with decisions.
4. Evidence that disputes regarding plans are investigated and results documented.

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[3] *Refers to the independent but interrelated agencies and other stakeholders who make up the state service system.*

[4] *Refers to the consumer.*

5. Evidence that the quality improvement system actively seeks feedback from individuals receiving services, support and/or treatment regarding their satisfaction, and that they are provided opportunities to express needs and preferences and the ability to make choices.
6. Evidence that the quality improvement system actively tracks individual outcomes in life domains and uses that information to improve person-centered planning processes.
7. Evidence that staff development plans include efforts to ensure that staff involved in managing, planning and delivering support and/or treatment services are trained in the philosophy and methods of person-centered planning.
8. Evidence that the quality improvement system includes processes for continual improvement of the quality of person-centered planning.
9. Evidence that plans meet the essential elements.